DEPARTMENT OF HEALTH
AND HOSPITALS
Aging and Adult Services

Assistive Devices and Medical Supplies Form

Participant's Name: _____ Regional Office (RO): _____

Address: _____

Responsible Representative (if applicable): _____

DOB: _____ Last 4 of SSN: _____

Total Estimated Cost: $ 0.00 Total Actual Cost: $ 0.00

$300 maximum total purchase cost for Assistive Device Z0624, with the Support Coordination Agency (SCA) as the billing source.
$300 maximum total purchase cost for Medical Supply Z0645 with the Support Coordination Agency (SCA) as the billing source.

I. Itemized Assistive Devices and Medical Supplies Expenses

Assistive Device(s) Z0624				
Item	Designated Purchaser's (DP) Name	Number of Items Requested	Estimated Cost *Completed with Section II*	Actual Cost *Completed with Section V*
Totals:	----------	0	$ 0.00	$ 0.00
Medical Supplies Z0645				
Totals:	----------	0	$ 0.00	$ 0.00

II. Pre-Approval Authorization

Pre-Approved Authorization Amount Total for Assistive Device(s) Z0624: $ 0.00 (estimated cost total)

Pre-Approved Authorization Amount Total for Medical Supplies Z0645: $ 0.00 (estimated cost total)

SC Signature: _____ Date: _____

SC Supervisor Signature: _____ Date: _____

III. Support Coordination Agency

SC: _____

Agency: _____

Address: _____

Phone Number: _____

E-mail Address: _____

SC Signature: _____ Date: _____

IV. Designated Purchaser (DP)

Name: _____

Agency: _____ *if applicable*

Address: _____

Phone Number: _____

E-mail Address: _____

DP Signature: _____ Date: _____

V. Final Approval *completed by the SC Supervisor*

By signing, I verify, as the SC Supervisor, that I have reviewed this form and the item receipt(s) for completeness, compliance and for actual expenditure.

Participant Name: _____

DOB: _____ Last 4 of SSN: _____

Authorization Amount Total for Assistive Device(s) Z0624: $ 0.00 (actual cost total)

Authorization Amount Total for Medical Supplies Z0645: $ 0.00 (actual cost total)

SC Signature: _____ Date: _____